TRENDS IN PRIVATE HEALTH INSURANCE AND ISSUES AFFECTING FAMILIES AND PEDIATRIC PROVIDERS

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ABSTRACT

This paper provides an overview of recent developments in employer-sponsored health insurance and concludes with a summary of their likely impacts for families, particularly those whose children have special needs and the pediatric providers who care for them. Between 2010 and 2014, family health insurance premiums increased by 22%. At the same time, the proportion of firms offering health benefits declined by 20%. While the selection of preferred provider organization (PPO) plans remained constant during this time period, there was a 50% growth in the selection of high deductible health plans (HDHPs) and a corresponding decline in selection of health maintenance organization (HMO) plans. Since 2010, there has been a 28% increase in annual deductibles among PPOs and a 19% increase among HDHPs. Based on an analysis of these employer-sponsored benefit plan changes since the Affordable Care Act (ACA) was implemented in 2010 and emerging industry trends, several issues are of particular significance for families and their pediatric providers. These include significant increases in cost-sharing obligations, greater use of restricted provider networks, employers transitioning from offering health insurance benefits toward offering capped contributions toward health care, and increasing use of private health insurance exchanges modeled after the ACA exchange structure. Several recommendations are suggested for consideration by policymakers, employers, insurance carriers, and health professional and family organizations. The tradeoffs between premium cost and out-of-pocket financial liabilities needs to be more clearly explained to families. In addition, families need current information about whether their children's doctors and other pediatric providers are included in the private plan networks they enroll in. Finally, mechanisms are needed to continuously monitor private health insurance trends as they affect children, particularly related to medical debt, pediatric network adequacy, and access to care for children with special health needs (CSHCN).

INTRODUCTION

Employers are in the midst of making significant changes to their private health insurance products for several reasons. Chief among them has been the Affordable Care Act (ACA) requirement to stay below the 2018 excise tax on plans considered to be "high cost."[1] Specifically, fully insured and self-funded plans were to be charged a 40% tax on the dollar amount of employee premiums beyond the annual limit of $27,500 for family coverage and $10,200 for individual coverage, not including stand-alone dental and vision plans. However, at the end of 2015, Congress voted to postpone this "Cadillac" tax until 2020, and in President Obama's 2017 budget plan, adjustments were made in the excise tax to reflect regional differences. Despite efforts to delay or appeal implementation of this excise tax, the impact of this proposal has been widely felt among employers.

A 2014 Towers Watson Survey found almost half (48%) of large employers are likely to reach the trigger unless additional cost-cutting changes are made.[2] Other ACA factors stimulating private insurance market changes are the added costs to insurers as a result of the essential health benefit requirements and elimination of pre-existing condition exclusions, dramatic expansions in the individual private insurance market, and new incentives for payment innovations.[3]

The American Academy of Pediatrics, supported by a grant from the Catalyst Center at Boston University, developed this white paper to analyze emerging trends in the private health insurance marketplace and their implications for families whose children have special needs and for their pediatric health care providers. The audience for this paper includes policymakers, employers and private insurance carriers, pediatric providers, and family and disability organizations. It is organized into four sections: 1) prevalence of special needs and insurance status, 2) trends in employer-sponsored health benefits between 2010 and 2014, 3) changes that employers are considering to contain private health insurance costs, and 4) implications and recommendations. The appendix includes a case study

of a large New York commercial carrier and its various products and associated cost-sharing obligations and out-of-network provider coverage.

SECTION 1. BACKGROUND ON PREVALENCE OF SPECIAL NEEDS AND INSURANCE STATUS AMONG CHILDREN

Key Findings:

- One quarter of American households has one or more children with special health needs
- Although the proportion of children with private coverage has been declining in recent years, the majority of US children are privately insured (59%).
- Among children with special needs, 52% are privately insured.

According to the National Survey of Children's Health, 20% of US children under the age of 18 have a special health care need, and 26% of American households have one or more children with special needs.[5] This latter prevalence figure is important to use when addressing family coverage.

Turning next to insurance status, the majority of children in the United States are privately insured. Although this number has been declining in recent years,[6] national estimates for 2014 from the National Health Interview Survey reveal that 59% of children, ages 18 and under, were privately insured, 38% were publicly insured, and 6% were uninsured.[7] The distribution of coverage for children varies significantly by age, as shown in Table 1.

Table 1. Health Insurance Coverage for Children by Age, 2014

Group		Insured	Private	Public	Both (Public & Private	Uninsured
0-18	77,866,117	72,956,241	46,071,116	29,705,954	2,820,829	4,909,876
	100%	94%	59%	38%	4%	6%
0-5	23,702,387	22,531,206	12,886,537	10,465,207	820,538	1,171,181
	100%	95%	54%	44%	4%	5%
6-18	54,163,730	50,425,035	33,184,579	19,240,747	2,000,291	3,738,695
	100%	93%	61%	36%	4%	7%
19-25	31,230,002	24,994,553	21,047,835	4,603,896	657,178	6,235,449
	1000%	80%	67%	15%	2%	20%

Source: Special tabulations of the 2014 National Health Interview Survey prepared by the State Health Access Data Assistance Center at the University of Minnesota.

Comparable estimates of the insurance status of CSHCN are not available. However, data from the 2009/10 National Survey of Children with Special Needs show that a smaller proportion of children with special needs are privately insured compared to those without special needs. Still, about half (52%) of CYSHCN under the age of 18 were privately insured in 2009/10, 36% were publicly insured, 8% were both privately and publicly insured, and 4% were without any coverage at all.[8] As CYSHCN get older, they – similar to children without special health care needs – are more likely to be privately insured.[9] Importantly, this national survey reveals that over a third of privately insured parents whose CSHCN have special needs report that their current insurance is inadequate because of limited benefits, high out-of-pocket expenses, and/or difficulty accessing needed health providers.[11]

SECTION 2. TRENDS IN EMPLOYER-SPONSORED HEALTH BENEFITS: 2010, 2012, AND 2014

Major Findings:

- Across all types of employer-sponsored health plans, premiums for family coverage rose by 22% between 2010 and 2014, from $13,770 to $16,834.
- Fewer employers offered health benefits to their employers in 2014 compared to 2010 – 55% versus 69%.
- PPOs continue to be the type of health plan that most covered workers select. However, between 2010 and 2014, there was a marked increase in enrollment in high deductible health plans with a savings option (HDHP/SO) and a corresponding decrease in HMO enrollment.
- Use of deductibles is widespread, except among HMOs, and amounts have been steadily increasing. In 2014, the average aggregate deducible in a PPO was $2,000, which represents a 20% increase; for a HDHP/SO, it was $4,522, up 19%; and for an HMO, it was $2,328, up 76%.
- Few changes have been made in copayments and coinsurance for primary and specialty care physician office visits during this time period.
- Annual family out-of-pocket maximum amounts have been capped under the ACA -- $12,700 in 2014. Among HDHP/SOs, 32% set their aggregate out-of-pocket maximum amount at $10,000 or more, and among PPOs, 17% set this same high maximum.

The annual survey of employer health benefits, conducted by the Kaiser Family Foundation and the Health Research and Educational Trust (HRET), provides a comprehensive summary of important trends in private health insurance offered by small, medium, and large firms. The trends reported below pertain to *family* health insurance premiums, plan enrollment, and cost sharing from 2014,[12] 2012,[13] and 2010.[14]

1. Premiums. In 2014, the average annual premium for family coverage for all types of employer-sponsored insurance plans was $16,834. This premium amount represents a 6% increase since 2012 and a 22% increase since 2010, as shown below in Table 2. Although the average annual family premiums for HMOs and PPOs were similar, they were about $2,000 more expensive than high deductible health plans with a savings option (HDHP/SOs) and about $1,300 more expensive than point of service (POS) plans. Covered workers, on average, contribute 29% of the cost of premiums for family coverage. This contribution percentage has changed little between 2010 and 2014.

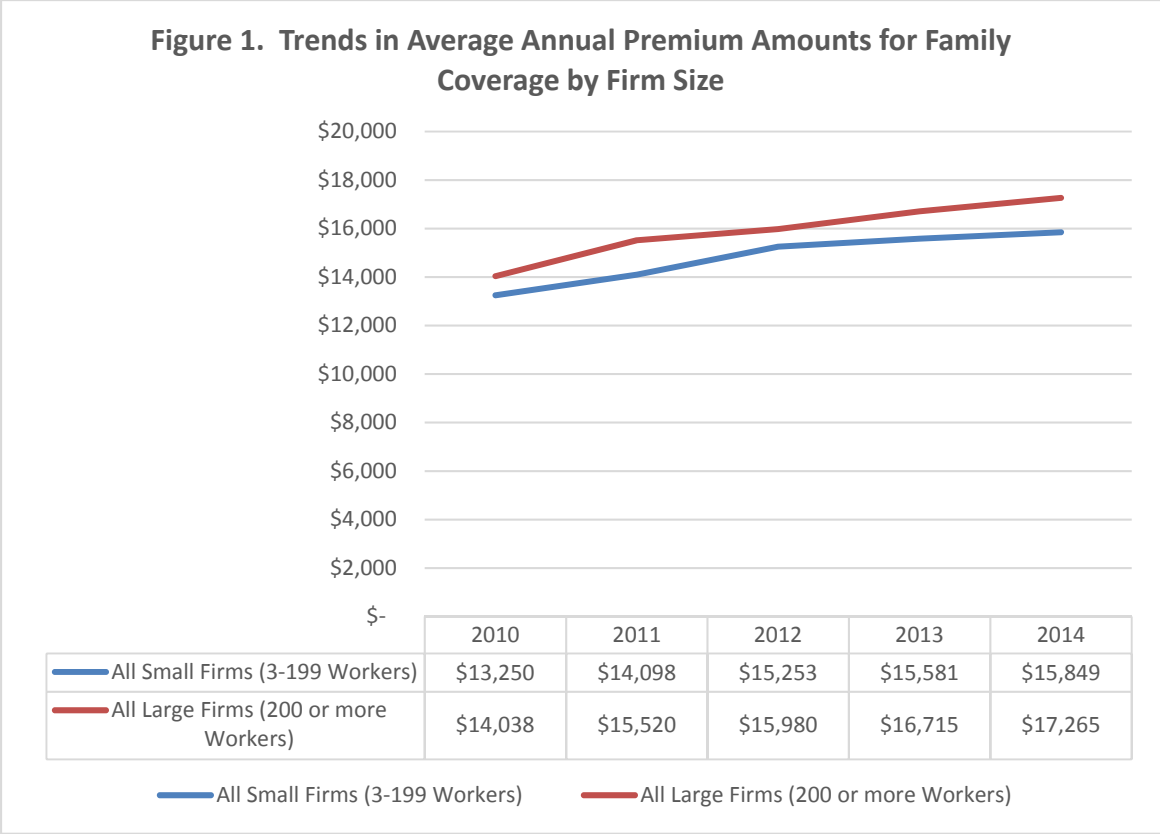
Table 2. Trends in Average Annual Premium Amounts for Family Coverage by Plan Type

Plan Type	2010	2012	2014
All Plans	$13,770	$15,745	$16,834
PPO Plans	$14,033	$16,356	$17,333
HMO Plans	$14,125	$15,729	$17,383
POS Plans	$13,213	$15,378	$16,037
HDHP/SO Plans	$12,384	$14,129	$15,401

As shown in Figure 1, premiums for both small and large firms have seen a similar increase since 2010 (25% for small and 26% for large). For small firms (3 to 199 workers), the average family premium rose from $13,250 in 2010 to

$15,849 in 2014. For large firms (200 or more workers), the average family premium rose from $14,038 in 2010 to $17,265 in 2014.

Figure 1. Trends in Average Annual Premium Amounts for Family Coverage by Firm Size



	2010	2011	2012	2013	2014
All Small Firms (3-199 Workers)	$13,250	$14,098	$15,253	$15,581	$15,849
All Large Firms (200 or more Workers)	$14,038	$15,520	$15,980	$16,715	$17,265

SOURCE: Kaiser/HRET Survey of Employer Sponsored Benefits, 1999-2014

2. **Types of Plans Offered**. In 2014, more than 55% of firms offered health benefits to their employees, down from 61% in 2012 and 69% in 2010. Small firms (< 200 workers) are much less likely to offer health insurance compared to large firms primarily because the cost is too high. Among firms offering benefits, almost all large firms extend coverage to spouses and dependents. Among small firms that offer health insurance, 4% currently do not provide coverage to spouses, and 8% do not cover dependents. Typically, employers offer only one type of health plan. More than a quarter of firms changed their insurance plan in 2014.

The most popular plan offered by both small and large employers in 2014 was a PPO product, as shown in Table 3. More than half of employers offered a PPO plan, and about a quarter offered a HDHP/SO with the same proportion offering a POS product. Only 13% of employers gave their workers an HMO choice in 2014 reflecting a trend of decreased offering of this option. As shown below, the types of plans offered have shifted over time away from HMOs in favor of HDHP/SOs for both small and large firms. Four out of five workers who are offered health insurance benefits by their employers take the coverage.

Table 3. Trends in Distribution of Firms that Offer the Following Plan Types

	2010			2012			2014		
Plan Type	Small Firms 3-199 workers	Large Firms 200 + workers	All Firms	Small Firms 3-199 workers	Large Firms 200 + workers	All Firms	Small Firms 3-199 workers	Large Firms 200 + workers	All Firms
PPO	51%	83%	53%	42%	76%	42%	54%	73%	55%
HMO	24%	32%	24%	20%	28%	21%	12%	26%	13%
POS	25%	12%	25%	25%	14%	25%	23%	13%	23%
HDHP/SO	15%	25%	15%	31%	34%	31%	27%	39%	27%

3. **Health Plan Enrollment**. Most covered workers elect to enroll in a PPO plan for their insurance, followed next by a HDHP/SO, an HMO, and a POS plan, as shown in Table 4. While there has been little change in the proportion of workers selecting a PPO since 2010 in small and large firms, there has been a marked reduction in enrollment in HMOs and a corresponding increase in enrollment in HDHP/SO – similar to the offer patterns noted earlier.

Table 4. Trends in Distribution of Health Plan Enrollment for Covered Workers by Plan Type

	2010			2012			2014		
Plan Type	Small Firms 3-199 workers	Large Firms 200 + workers	All Firms	Small Firms 3-199 workers	Large Firms 200 + workers	All Firms	Small Firms 3-199 workers	Large Firms 200 + workers	All Firms
PPO	51%	63%	58%	43%	63%	56%	46%	63%	58%
HMO	18%	21%	19%	15%	16%	16%	12%	13%	13%
POS	15%	5%	8%	18%	4%	9%	17%	4%	8%
HDHP/SO	16%	12%	13%	24%	17%	19%	24%	19%	20%

4. **Cost Sharing**

A. **Deductibles.** Use of deductibles is widespread, except in HMOs, as shown in Table 5, and deductible amounts have been steadily increasing. All HDHP/SO plans, as its name implies, have a deductible.[4] Most PPOs and POS plans have an annual deductible (85% and 70%, respectively), but less than 40% of HMOs have one. Since 2010, the percentage increase of HMOs using a deductible rose by 30%, and the percentage increase of PPOs using a deductible rose by 10%. In structuring the type of deductible to use, firms can select either an aggregate amount, which means that all family members' out-of-pocket costs count toward the deductible, or a separate per person deductible, which means that individual members of the family meets a separate per-person deductible. Across firm size (small and large) aggregate deductibles are far more widely used than separate per-person deductibles. In 2014, the average aggregate deductible for workers enrolled in a PPO in all firms was almost $2,000, an increase of 28% since 2010. For those with HMO coverage, the aggregate deductible was somewhat higher for all firms ($2,328). This deductible amount increased 76% from 2010. For those in a HDHP/SO plan, the aggregate deductible across all firms was $4,522,

which has increased 19% since 2010. It is important to note that workers in small firms are three times as likely as those in large firms to have an aggregate deductible of $2,000 or more.

Among covered workers with a separate per-person deductible, in 2014 across all firms, the average amount per person was highest in an HDHP/SO, at $2,116, followed by $1,153 in a POS plan, $870 in an HMO, and $821 in a PPO. In 2014, a third of all plans using this type of deductible required that three people within the family meet the per-person amount, and 26% required 4 people. Since 2010, a higher proportion of HMO, HDHP/SO, and especially PPO plans are using separate per-person deductibles, as shown in Table 5. It is important to note that often deductibles are not applied to primary care physician office visits and prescription drugs, especially in PPOs and HMOs, as shown in Table 6.

Table 5. Trends in Distribution of Plans with No General Annual Deductible and Types and Amounts of Deductibles by Plan Type

Plan Type	No Annual Deductible			Aggregate Deductible			Per Person Deductible		
	2010	2012	2014	2010	2012	2014	2010	2012	2014
PPO									
Small Firms	20%	24%	17%	56% $2,347*	47% $2,956*	51% $3,231*	24% $1,065*	29% $1,014*	33% $1,282*
Large Firms	24%	23%	15%	47% $1,103*	45% $1,364*	43% $1,463*	29% $430*	32% $523*	42% $708*
All Firms	23%	23%	15%	50% $1,518	45% $1,770	45% $1,947	27% $596	32% $632	40% $821
HMO									
Small Firms	65%	67%	41%	28% $2,138*	24% NSD	41% $2,817	7% NSD	9% NSD	18% NSD
Large Firms	75%	71%	72%	18% $774*	15% $914	17% $1,845	7% $344	14% $516	11% $482
All Firms	72%	70%	63%	21% $1,321	18% $1,329	24% $2,328	7% $500	12% $754	13% $870
POS									
Small Firms	32%	42%	31%	50% $2,596	33% $2,643*	59% $3,079*	18% NSD	25% NSD	10% NSD
Large Firms	30%	37%	28%	62$ 1,806	47% $1,516*	62% $1,481*	8% NSD	17% NSD	10% NSD
All Firms	31%	40%	30%	54% $2,253	38% $2,163	60% $2,470	14% $1,164	22% $1,092	10% $1,153
HDHP									
Small Firms	NA	NA	NA	85% $4,306*	77% $4,456*	88% $5,602*	15% NSD	23% NSD	12% NSD
Large Firms	NA	NA	NA	91% $3,429*	87% $3,603	83% $3,894*	9% $1,815	13% $2,490	17% $1,818
All Firms	NA	NA	NA	89% $3,780	83% $3,924	85% $4,522	11% $2,053	17% $2,821	15% $2,126

Small Firms: 3-199 Workers Large Firms: 200 or More Workers NSD: Not Sufficient Data NA: Not Available

* Estimates are statistically different within plan and deductible type between small and large firms ($p < .05$)

Table 6. Trends in Distribution of Plans with a General Annual Deductible Excluding Certain Services from Meeting the Deductible by Plan Type

	Primary Care Physician Office Visits			Prescription Drugs		
Plan Type	2010	2012	2014	2010	2012	2014
PPO	70%	78%	78%	92%	94%	93%
HMO	83%	87%	76%	94%	88%	95%
POS	81%	79%	68%	92%	91%	89%
HDHP/SO	37%	46%	51%	56%	79%	78%

B. **Copayments and Coinsurance.** Limited information is available on copayments and coinsurance from the Kaiser/HRET survey because of the complexity of cost-sharing provisions in health plans. What they do report on pertains to physician services, as shown in Table 7. For both primary and specialty care physician office visits copayments are the most common form of cost sharing in all plan types except for HDHPs. Since 2010, there have been few changes in the use of copayments and coinsurance among PPOs and HMOs, but among HDHP/SO, there has been a somewhat higher percentage using copayments and also using coinsurance rather than exempting at least primary care physician services from cost sharing. In 2014, the average copayment charge for a primary care office visit was $24 and for a specialty care visit, $36. The average coinsurance rate was 18% for a primary care visit and 19% for a specialty care visit.

Table 7. Trends in Distribution of Plans by Type of Cost Sharing for Primary (P) and Specialty (S) Care Office Visits by Plan Type

Plan Type	Copay Only (P/S)			Co-Insurance Only (P/S)			No Cost Sharing (P/S)		
	2010	2012	2014	2010	2012	2014	2010	2012	2014
All Plans (%)	75/73	73/73	73/72	16/17	17/19	18/21	5/6	8/7	8/6
PPO (%)	80/77	80/80	83/82	16/17	14/16	12/16	1/3	4/2	3/1
HMO (%)	94/93	96/93	89/90	1/1	1/3	5/6	1/2	2/3	5/3
POS (%)	90/90	92/88	94/94	4/5	3/4	1/2	2/2	5/8	5/3
HDHP/SO (%)	15/13	17/19	20/18	51/50	53/53	56/58	30/22	30/28	24/23

C. **Annual Out-of-Pocket Maximum Amounts.** According to the ACA, in 2014 across all firms, health plans set their out-of-pocket maximum at $12,700 or less for family coverage (with increases in subsequent years). As shown in Table 8, plans differ in how they establish their out-of-pocket maximum, using either an aggregate amount or a separate amount per person – as they do with deductibles. Among covered workers with PPO or HMO coverage in all firms, somewhat less than two-thirds are in plans that have an aggregate maximum amount. In contrast, more than 80% of covered workers in POS and HDHP plans across all firms have an aggregate maximum amount. A sizeable proportion of covered workers with family coverage must reach an aggregate amount of $10,000 or more – 32% in HDHPs, 21% in POS plans, and 17% in PPO and HMO plans.

Table 8. Trends in Distribution and Type of Out-of-Pocket Maximum for Covered Workers with Family Coverage by Plan Type

Plan Type	No Deductible Limit			Aggregate Amount			Separate Amount Per Person		
	2010	2012	2014	2010	2012	2014	2010	2012	2014
PPO									
Small Firms	19%	18%	10%	58%	70%	60%	23%	22%	20%
Large Firms	11%	8%	4%	65%	61%	62%	24%	30%	35%
All Firms	13%	10%	6%	63%	63%	62%	24%	28%	31%
HMO									
Small Firms	40%	47%	4%	47%	71%	43%	13%	10%	25%
Large Firms	37%	23%	13%	49%	61%	55%	14%	23%	26%
All Firms	38%	30%	10%	48%	64%	51%	14%	19%	25%
POS									
Small Firms	17%	26%	14%	56%	84%	62%	7%	12%	2%
Large Firms	19%	20%	10%	71%	79%	67%	9%	13%	11%
All Firms	30%	24%	12%	62%	82%	64%	8%	13%	5%
HDHP									
Small Firms	8%	8%	2%	81%	88%	78%	10%	14%	10%
Large Firms	1%	<1%	<1%	93%	86%	91%	5%	9%	14%
All Firms	4%	4%	1%	88%	86%	85%	7%	11%	13%

SECTION 3. EMERGING PRIVATE INSURANCE DIRECTIONS

Major Findings:

- Mid-to-large employers and plans are increasing the use of narrow provider networks and retail clinics.
- Employers are experimenting with a variety of value-based plan designs.
- More large employers are considering capping their contributions to health insurance and moving toward a private exchange approach modeled after the ACA.

A 2015 Towers Watson Survey of mid-to-large employers revealed that 84% of US employers are planning to make major changes to their employee health benefit programs over the next three years.[15] Among the most popular changes expected are reductions in premium subsidies for spouses and dependents, capping employer contributions to health benefits to a flat dollar amount, greater use of centers of excellence and narrow provider networks, and restrictions on specialty pharmacy benefits. In addition, almost 20% report that they are considering the use of private exchanges (analogous to state and federal exchanges) for their full-time employees in 2016 and 37% by 2018. Summarized below is a brief discussion of the most common planned benefit design changes by private carriers.

1. **Narrow/Tiered Provider Networks**. According to the Kaiser/HRET survey of employers, 19% of Employers offering health benefits include a tiered/high-performance provider network up from 16% in 2010. These networks generally have lower costs than conventional open access PPOs or standard HMOs. Narrow networks are gaining ground, especially in the Northeast, with 27% of firms including such a network (up from 15% in 2010) and in the West, with 24% including such a network (up from 18% in 2010). In more than half of firms offering restricted provider networks, quality and cost efficiency are used as the criteria for selection; but, in about a third of plans, the selection criteria is based solely on cost efficiency. BDC Advisors, a health care strategy consulting firm, predicts that narrow network products offered in the market in the next decade will be substantially different than in the past. Based on surveys of national and regional health plans, they anticipate narrow network changes will include "aggressive" out-of-network benefit control, new performance measurement management tools, pay-for-performance and accountable care risk-sharing arrangements, and care coordination instead of medical necessity reviews. BDC Advisors also reports that these narrow networks will need to have a 20%-25% price advantage over PPO and HMO products to encourage firms to change from open access plans.[16] Several major insurers, including United Health Group and Blue Shield of California, are forming accountable care organizations with networks of hospitals, health systems, clinics, and physician groups --referred to as clinically integrated networks.

2. **Retail Clinics.** The Kaiser/HRET employer survey reports that in 2014, 57% of all employers offering health benefits cover retail clinics in their largest plan (similar to what was found in our sample plan in the Appendix). The proportion is higher (67%) among large firms. Eight percent of these firms offer a financial incentive to use retail clinics instead of the physician's office. Again, among large firms this percentage is higher – 14%. According to Accenture researchers, the number of walk-in medical clinics is expected to increase by an annual rate of 25-30%, bringing the number of retail clinics to more than 2,800 by 2015, with the ability to serve almost 11 million patient visits annually. As Kaveh Safavi, an Accenture expert noted, "Retail clinics could serve as a 'release valve' for primary care providers and hospitals that could be strained as the influx on newly insured consumers enters the market."[17] Cleveland Clinic, Henry Ford Health System, and other health systems are increasingly affiliating with retail clinics to gain PCP and specialist referrals and to monitor the quality of care delivered by the retail clinics.

3. **Value-Based Benefit Design.** Value-based insurance design is intended to increase health care quality and decrease costs by using financial incentives to either promote cost effective health care services and consumer choices and discourage utilization of unnecessary or repetitive services. Value-based benefit designs generally include several strategies, including wellness initiatives, disease management, and use of cost-sharing differentials. Wellness initiatives are primarily targeted to employees, not their dependents, and include incentives for lifestyle management -- smoking cessation, healthy eating, and exercise, for example. Disease management strategies are gaining in importance, with plans and their networks identifying high–cost patients and those with certain chronic conditions (eg, diabetes) to focus their care coordination and self-management efforts. Disease management strategies sometimes come with copay or coinsurance differentials or cash equivalents for adherence to evidence-based guidelines including prescription drug use adherence, as well as to participation in disease management programs. Again, these are primarily aimed at adults. Another strategy is the use of cash or premium differentials for employees based on health risk assessment results, biometric testing, and/or participation in wellness programs.

4. **Private Exchanges.** Private exchanges, run by private companies like Aon, Hewitt, or Mercer, are gaining momentum within the employer-sponsored market to save administrative costs and to better manage Health Savings Accounts. This strategy, modeled after ACA exchanges, is also consistent with the shift to a defined employer contribution for coverage and a move away from employers offering self-funded plans. Regional carriers, such as Cigna, United, and BlueCross BlueShield have also entered this market -- partnering with technology platforms or investing in their own technology. These exchanges -- serving either a single carrier or multiple carriers -- provide an online approach for purchasing group coverage and other consumer tools, including cost calculators, physician finders, and questionnaires to help in plan selection. Projections show that an estimated 40 million will be enrolled in these private exchanges by

2018, making the private exchange market about 24% of the total employer market.[18] Large firms are more likely than small and medium firms to be considering this option.

SECTION 4. MAJOR PRIVATE INSURANCE TRENDS AFFECTING FAMILIES AND PEDIATRIC PROVIDERS

Major Findings:

The most significant changes that are likely to impact families, particularly those with CSHCN, and their pediatric providers are:

- Dramatically increasing cost-sharing obligations, specifically the use of deductibles and high out-of-pocket maximum amounts that families will be liable for.
- Greater use of restricted provider networks, requiring families to pay more if their pediatric providers are not in the preferred networks.
- Employers moving toward defined premium contributions instead of offering employer-sponsored health plans.
- Increasing use of private exchanges modeled after ACA exchanges.

This decade marks the most significant changes in health insurance since the introduction of Medicare and Medicaid in the mid-1960s. In addition to major expansions of Medicaid called for in the Affordable Care Act (ACA), changes in the private insurance market are substantial.[19] Among the most significant changes for families are individual and employer requirements and penalties for offering health insurance, financial assistance to certain individuals and employers, new federal and state exchanges through which to purchase coverage, definition of a standard set of essential health benefits, prohibition against pre-existing conditions exclusions and removal of lifetime limits on payment of covered benefits, extension of dependent coverage to age 26 on parent's private insurance plans, and use of new reimbursement and quality of care initiatives.

This paper summarizes employer-based insurance trends resulting from the ACA and ever-increasing pressure on employers to lower insurance costs and their implications for families with CSHCN and pediatric clinicians. Between 2010 and 2014, premiums for family coverage rose by 22%. The percentage of firms offering health benefits declined by 20%. While the percentage of covered workers selecting PPO plans remained the same, there was a 50% growth in HDHP selection and a corresponding decline in HMO selection. With regard to the use and amount of deductibles since 2010, the report finds a 69% increase in the use of annual deductibles across all plans. Among those with PPO plans, the average annual family deductible of $1,947 increased by 28% since 2010, and among those with HDHP/SOs, the deductible was $4,522, an increase of 19%. Annual out-of-pocket maximums can no longer exceed $12,700 for a family, according to the ACA. Still, in 2014, 32% of HDHP/SO plans and 19% of PPO plans had an out-of-pocket limit for covered families of $10,000 or more. Based on the review of sample small and large group products and a HDHP/SO plan (in appendix), one can see plans' reliance on narrow provider networks, the wide range of deductible choices which are typically applied to almost all services, the high out-of-pocket limit, and the elevated cost-sharing requirements for hospital services and non-generic prescriptions.

Increased Cost Sharing by Families. With regard to higher cost-sharing, new research shows that among all households with children, 24% do not have enough liquid assets to pay a $2,400 family deductible, and 35% do not have enough to pay a $5,000 deductible.[20] Among families with incomes between 100-250% FPL, these percentages increase to 55% and 68%, respectively. Even among families with incomes between 250% and 400%, affordability of deductibles is a huge issue – 35% are without adequate liquid assets to pay a $2,400 deductible and 51% without ready assets to pay for a $5,000 deductible 2014 report from the Consumer Financial Protection Bureau (CFPB) found that medical debts account for half of debt collections actions that appear on consumer credit reports.[21] Also, the Kaiser Family Foundation found that in 2014, 1 in 3 Americans struggle to pay medical bills, and that 70% who do so are insured.[22] These studies indicate that having health insurance is not sufficient to ensure adequate cost-sharing

protection. Since families whose children have special needs use more health care, they will be faced with greater risk of medical debt and the providers who care for them will more likely be faced with higher overhead expenses for billing and late collections As noted in the Kaiser report, once in debt, families often delay or forego needed care to avoid incurring further unaffordable medical bills.

Narrow and Tiered Provider Networks. With regard to the use of narrow networks – whether in HMOs, PPOs, or HDHPs—families whose children rely on specialty providers, including pediatric subspecialists and children's hospitals, may not be included in plans' preferred provider networks, resulting in problems with access to care, quality, and continuity as well as financial burdens if families go out-of-network for their child's care. There is growing evidence of concerns regarding the use of narrow networks, particularly in State Health Insurance Marketplace products. Officials and health providers in several states – for example, Maine, Mississippi, New Hampshire, Pennsylvania, South Dakota, and Washington -- are taking steps, including legislative actions, to restrict insurance plans that limit doctor and hospital choices. [23] In addition to narrow provider networks, the use of tiered networks is gaining popularity. This is a way that health plans assign different cost-sharing amounts to incentivize the use of certain providers over others. Research on the impact of narrow/tiered networks on families is limited. Studies show that loyalty to current providers and income are key factors in choosing to remain with a physician even if that physician is a non-network provider or lower tier provider. The Kaiser Foundation Tracking Poll on Narrow Networks[24] found that that, in general, the public leans towards more expensive plans with broader networks. About half say they would rather have a plan that costs more money, but allows them to see a broader range of doctors and hospitals, while 37% prefer a plan that is less expensive but allows them to visit a more limited range of providers. While older individuals and those with higher incomes show a clearer preference for more expensive plans with broader networks, younger adults and those with lower incomes are more evenly divided in their preferences. The effect of tiered provider networks appears to be among patients who choose new physicians who are at lower tiers as opposed to moving patients to the higher tiered or "better" performers. These findings suggest strong loyalty of patients to physicians more likely to be considered their personal doctor.[25] However, there is evidence to suggest that health care consumers will switch to preferred providers when the price differential between preferred and non-preferred providers is large [26, 27] An additional concern is that quality and cost efficiency metrics used by health plans may not pertain to pediatric specialty/chronic care and may not be well understood by consumers.[28] In an effort to establish a uniform basis from which states can address provider network regulatory issues, the National Association of Insurance Commissioners (NAIC) published a set of network adequacy standards in 2015, called the Health Benefit Plan Network Access and Adequacy Model Act .[29] These standards call for a "sufficient" number and type of providers to ensure that covered services for children and adults " will be accessible without unreasonable travel or delay. Insurance regulators are recommended in NAIC's drafting note to carefully review carrier network filings to ensure that the network design is not potentially discriminatory for children and adults with serious, chronic, or complex health conditions. The standards also call for carriers to establish a process to access to out-of-network providers if there is unreasonable travel or delay.

Defined Premium Contributions and Private Health Insurance Exchanges. Finally, the fact that more employers are electing to provide a capped premium contribution towards insurance coverage instead of offering their own health insurance benefit plan is likely to result in erosion of employer-based health insurance. While defined contribution plans provide opportunities for portability and control by the employee, the purchase decision shifts from the employer to the employee. Research has shown that when families are given the choice of health plans, they often make their decision on the basis of premium price.[30] Consequently, HDHP/SO plans – typically the lowest priced plan option – are favored.

SECTION 5. RECOMMENDATIONS

The following recommendations should be considered by employers, policymakers, insurance regulators, pediatric professional organizations, and family and disability groups.

Increased Cost Sharing by Families

1. Families need to be better informed about the tradeoffs between premium price and out-of-pocket financial liabilities with improved decision-making tools and supports.
2. Research needs to continue on the impact of increased family cost sharing, particularly on access and affordability.

Narrow and Tiered Provider Networks

3. Families need current information at the time of plan selection about whether their children's doctors and other pediatric health care providers are included in the plans they select and, if so, whether there are higher cost-sharing requirements for certain pediatric providers.
4. Prior to going to market, state insurance regulators should ensure that insurance products do not discriminate against children and adolescents with chronic conditions and that health carriers have a process in place to ensure in-network levels of cost sharing for children that have to go out-of-network or cross state lines to obtain timely and high quality access to pediatric specialty care.
5. Provider network adequacy standards for pediatric specialty care, including mental health care, medical subspecialty care, hospital care, home health care, and rehabilitative services, will be important to monitor and update in light of private health insurance trends.

Defined Premium Contributions

6. State and federal policymakers need to actively monitor access issues by analyzing policyholders' medical debt, use of out-of-network services, consumer satisfaction scores, appeals submitted by families whose children have special needs, and complaints filed with states' departments of insurance.

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APPENDIX A

EXAMPLE OF COMMERCIAL PLAN OFFERINGS BY A MAJOR COMMERCIAL CARRIER

This summary provides a detailed example of one plan's benefits and cost sharing for its most commonly sold products. This information was collected from a major regional private insurance carrier based in New York, in response to AAP's request. This summary reveal the use of restricted provider networks, the lack of out-of-network coverage, variable cost-sharing options, and high out-of-pocket maximum amounts that families must reach.

Although premium information was unavailable, this summary shows the large group plan offering the most generous coverage and cost-sharing option. Deductibles in these plans range from $0 to $9,000 for families depending on the product they enroll in, and deductibles are applied to most services, except in the large group plan. The out-of-pocket maximum varies little, with one exception, and it is about $12,000 – a high amount for a family to expend out-of-pocket before covered services are fully paid for by the insurer. Copayment amounts in two of the plans are very high for hospital services -- $1,000 per admission in one plan or $250/day up to five days for the other. Durable medical equipment (DME) cost sharing is also very high in three of the four plans. In the plans using coinsurance, rates are 10% in the HMO small group plan and range from 0-30% in the HDHP/SO plan, depending on what the employer or worker selects. Prescription drug cost sharing in the HDHP/SO has nine different payment options. Home health care is limited in all but the large plan, and physical, occupational, and speech therapies are limited in all four plans.

Below is a table outlining the plan features:

Appendix Table
Summary of Benefits and Cost Sharing in Commonly Sold Large, Small, and HDHP/SO Plans
Sold by a New York Regional Carrier

Benefits and Cost Sharing	Large Group Plan	Small Group Plans (2)		HDHP/SO Plan
▪ Plan Type	EPO[a]	HMO	HMO	EPO[b] with HSA
▪ HSA	NA	NA	NA	$750-$2,250[c]
▪ Overall deductible (family)	$0	$1,200	$2,600	$3,000-$9,000[d]
▪ Out-of-pocket limit (family)	$12,700	$8,000	$12,000	$7,000-$11,800[e]
▪ Primary care visit	$25/35	$25 after D	10% after D	0/10/20/30% after D[f]
▪ Specialist visit	$40/$50	$40 after D	10% after D	Same
▪ Retail clinic	$40/$50	$25 after D	NA	NA
▪ Online visit	$25/35	$25 after D	10% after D	Same
▪ Prescription drugs				
Generic	$10[g]	$10	10% after D	
Preferred/Formulary	$25[h]	$35	10% after D	[I] See ref. e
Non-preferred & specialty	$50	$60	10% after D	[j] See ref. e
▪ Labs/X-ray/MRI	$0/0/$50	$25/$40 after D	10% after D	Same
▪ Urgent care	$40/$50	$60 after D	10% after D	Same
▪ ER facility	$150	$150 after D	10% after D	NA
▪ Doctor services in hospital/surgical center	NS	$100 after D	10% after D	Same
▪ Hospital facility fee	$200/500/d/5	$1,000/adm after D	10% after D	Same
▪ Home Health care	$0/100/yr	$25 after D/40 visits	10% after D/40	Same/100/yr
▪ PT/OT/ST	$25-$50/60 c/yr	$30 after D/60 c/life	10% after D/60yr	Same/60/yr
▪ DME	50%	20% after D	10% after D	50% after D
▪ Use of out-of-network providers	Not covered	Not covered	Not covered	Not covered

Code: After D refers to after the deductible has been met

[a] An EPO is an exclusive provider network. No out-of-network providers are covered.

[b9] Ibid

[c] There are 9 options for annual HRA contributions by the employer for the family plan.

[d] There are 9 options for the deductible.

[e] There are 9 options for the out-of-pocket maximum.

[f] There are 4 options for coinsurance.

[g] Prescription drug deductible options $0, $50, $100, $250, $500. Other higher drug options available, including $10/50%/$3,000 for Tiers 1-3.

[h] This HDHP/So offers 9 options for prescription drugs for generic, preferred, and non-preferred drugs with different copay requirements and a prescription drug deductible.

[i] See ref. d.

j See ref. d.